Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012508	A. BUILDING: _____ B. WING _____	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was for a state home health complaint investigation. Complaint IN00134499 - Unsubstantiated: Lack of sufficient evidence. Survey Date: Septmeber 12, 2013 Facility #012508 Surveyors: Linda Dubak, R.N. Public Health Nurse Surveyor Foster Healthcare was found to be in compliance with 410 IAC 17-12-3 and 17-13-1 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN September 16, 2013	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE